STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155516	A. BUILDING 01 B. WING	05/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW MEMORIAL HOSPITAL-CCC	2200 RANDALLIA DRIVE FORT WAYNE, IN46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 05/16/11 Facility Number: 001203 Provider Number: 155516 AIM Number: N/A Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Parkview Memorial Hospital - CCC was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. The fully sprinklered Parkview Memorial Hospital - CCC is located on the fifth floor East and	K0000	This Plan of Correction constitutes our allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	West Wings of a nine story hospital of Type I (332) construction with a basement. The facility has a fire alarm system with smoke detection at the corridor smoke barrier doors, areas open to the corridor and all resident rooms. The facility has a capacity of 28 and had a census of 26 at the time of this survey. Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 05/23/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0044 SS=E	Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 Based on observation and interview, the facility failed to	K0044	1. Work order completed on 5/23/11 to repair the 5 South Fire	05/23/2011

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	ensure 1 of 5 fire door sets was arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows, at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice could affect all residents evacuated through the south wing exit stairwell in the event of an emergency. Findings include: Based on observation with the Facilities Manager on 05/16/11 at 12:50 p.m., the right side fire door (when entering the Orthopaedics Rehabilitation area from the south wing) failed to latch into the frame. Based on an interview with the Facilities Manager at the time of observation, these doors were fire		Door, Work Order #369492.2. 5 South Fire Door was repaired on 5/23/11. Door was cleaned and the panic hardware was lubricated. Operation was tested several times without failure; tight latch was obtained.3. All other fire doors on the Continuing Care Center were checked for a tight latch on 5/16/11.4. QA: Facilities Department will conduct a quarterly review of the fire doors located on the Continuing Care Center to ensure a tight latch.	

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	doors. 3.1-19(b)			
K0051 SS=D	A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 Based on observation and interview, the facility failed to ensure 1 of 1 smoke detectors in the resident room 554 was not installed where air flow would adversely affect its operation. Section 9.6.1.4 requires fire alarm systems comply with NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation	K0051	1. Work order completed on 5/17/11 to relocate the smoke detector in Room 554 to be at least 3 feet away from the air diffuser, Work Order #368908.2. Smoke detector was relocated at least 3 feet away from the air diffuser in Room 554 on 5/17/11.3. All other smoke detector locations were checked/verified for appropriate location on 5/16/11.4. QA: This deficiency will not need to be monitored through Quality Assurance since all smoke detectors are now within compliance.	05/17/2011

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	of the detectors. This deficient practice could affect 1 of 26 residents. Findings include: Based on an observation with the Facilities Manager on 05/16/11 at 1:05 p.m., the smoke detector in resident room 554 was located within three feet of a supply air duct. This was acknowledged by the Facilities Manager at the time of observation. 3.1-19(b)			